Client Information (Please Print)

Provider Name: Genardo Mental Health Counseling P.C

Client Name: _____ _____ _____
(Last) (First) (Middle Initial)

Home Address: _____ **Apt #** _____

_____ _____ _____
(City) (State) (Zip Code)

Home Phone: _____ **Other Phone:** _____ **Gender:** _____

Date of Birth: _____ Email address _____
Month / Day / Year

☐ Check here to receive email reminders

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner
Occupation: ☐ Full-Time ☐ Part Time ☐ Unemployed ☐ Full-Time Student ☐ Part-Time Student

Name of Employer/School: _____

Previous Mental Health Treatment (Within 2 years: ☐ Psychiatrist ☐ Psychologist ☐ LCSW-C ☐ Other

Mental Health Provider Name: _____

Insurance Information

Primary Insurance Company: _____ ID Policy # _____ Group # _____

Claims Address: _____ Phone: _____

Policy Holder's Employer: _____

Client's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Person Responsible for Account: ☐ Client ☐ Parent ☐ Other

_____ Date of Birth: _____ Phone # _____
Name (if different from client) Month / Day / Year

Effective Date of Insurance: _____ Social Security Number: _____

Policy Holder Name: _____ Date of Birth: _____
Month / Day / Year

Authorization to Bill:

Patient or Authorized person's signature: I authorize Genardo Mental Health Counseling P.C. and/or Headway to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims. I give permission to Genardo Mental Health Counseling P.C. to keep my credit card on file to pay for any copays or charge the full-service fee if my insurance does not cover the session or if I am not paying with insurance. If I choose to use Headway for billing my insurance, I agree to set up my Headway account at headway.co and complete all documents required by Headway prior to my first appointment with Genardo Mental Health Counseling P.C. If I do not set up a Headway account and complete all documents required by Headway prior to my first appointment with Genardo Mental Health Counseling P.C., I agree to let Genardo Mental Health Counseling P.C. charge my credit card on file for the full session fees.

Signed: _____ Date: _____

Mental Health Questionnaire

Date: _____ **Name:** _____ **DOB:** _____ ☐ **Male** ☐ **Female**

Marital Status: ☐ Married ☐ Never Married ☐ Domestic Partnership ☐ Separated ☐ Divorced

Presenting Concerns:

History of mental health treatment (Inpatient & Outpatient):

Substance abuse history:

Who lives in your household:

Do you have children that do not live with you? (names and age):

Legal issues/history:

Were you clinically diagnosed with a learning disability during your childhood? (If yes, describe):

Stressors (check all that apply)**:**

- ☐ Relationship problems
- ☐ Physical abuse
- ☐ Legal issues
- ☐ Difficulty with children
- ☐ Difficulty getting along with other children
- ☐ Verbal or emotional abuse
- ☐ Financial problems
- ☐ Employment concerns
- ☐ Difficulty with teachers
- ☐ Difficulty getting along with other people
- ☐ Sexual abuse
- ☐ Health concerns
- ☐ Moving a lot
- ☐ Schoolwork problems

What are your life stressors like:

What do you do for fun:

Do you identify with any religion or spiritual beliefs:

Who can you turn to for support:

Have you been the victim or perpetrator of physical or sexual abuse:

Have you been the victim or perpetrator of domestic violence?

Please list all prescribed mental health medications:

Is there anything else you feel we should know about?

Do you experience any of the following:

- ☐ Do you get suddenly overwhelmed?
- ☐ Do you experience rapid heartbeat?
- ☐ Are you fearful in crowds?
- ☐ Difficulty going to sleep
- ☐ Wake up at night
- ☐ Sleeping too much
- ☐ Nightmares
- ☐ Moody or crying more
- ☐ Feeling moody
- ☐ Trouble concentrating
- ☐ Trouble remembering
- ☐ Wanting to be alone a lot
- ☐ Excessive worry
- ☐ Can't stop washing hands or body, counting or checking on things
- ☐ Purposely cutting yourself
- ☐ Purposely burn self
- ☐ Purposely hitting self
- ☐ Other (explain):

- ☐ Do you get shortness of breath?
- ☐ Do you get shaky, dizzy, or lightheaded?
- ☐ Are you afraid to leave your home?
- ☐ Change in appetite
- ☐ Unintentional weight loss or gain
- ☐ Not hungry or not eating
- ☐ Feeling sick to your stomach
- ☐ Constipation or diarrhea
- ☐ Feeling guilty, worthless or hopeless
- ☐ Low energy
- ☐ Excessive energy
- ☐ Feeling like others are teasing you
- ☐ Hear things that no one else hears or is not present
- ☐ Seeing things that no one else sees or is not present
- ☐ Smell things that no one else smells or is not present

☐ Sexual issues ☐ Eating issues ☐ Death of a loved one ☐ Major loss or difficult changes

Do you have suicidal thoughts ☐ Yes ☐ No Do you have homicidal thoughts ☐ Yes ☐ No
Do you have access to firearms ☐ Yes ☐ No

Medical Questionnaire

Name: _____ ☐ **Male** ☐ **Female** **Date of Birth** _____

Height: _____ **Weight:** _____ **Date of last physical exam:** _____

Primary Care Physician: _____

Address: **Phone:** _____

_____

_____

_____

Allergies:	

List All Current Prescription Medications			
Medication	**Dosage**	**When Taken**	**Prescribed By**

List Any Medical and/or Psychiatric Diagnosis

Medical Questionnaire

Check if you have had any of the following:

- ☐ **Head injury**
- ☐ **Migraines or blurred vision**
- ☐ **Allergies to medications**
- ☐ **Surgery**
- ☐ **Cancer/tumor**
- ☐ **Asthma**
- ☐ **Chronic pain issues**
- ☐ **Lung infection**
- ☐ **Light headedness, dizziness**
- ☐ **Allergies**
- ☐ **Diabetes**
- ☐ **High blood pressure, rapid heartbeat**
- ☐ **Thyroid problem or goiter**

Are you pregnant: ☐ Yes ☐ No
Do you have regular periods: ☐ Yes ☐ No

Communicable Diseases			
	Last year tested	**Results**	**Comments**
Tuberculosis			
Hepatitis			
Ringworm			
Meningitis			
MMR			

Sexually Transmitted Diseases			
	Last year tested	**Results**	**Comments**
HIV			
Gonorrhea			
Venereal warts (HPV)			
Herpes			
Chlamydia			

Please list any other information that you feel may be necessary for us to know

Consent for Treatment
and Limits of Liability

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect: If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults: If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances: Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship Parents: or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers Insurance: companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications. You further agree to allow and accept wellness calls, wellness checks, and wellness visits from a crisis response team if the therapist feels it is warranted for any reason.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency. If you fail to attend three scheduled appointments in a three consecutive month period without notification, you will be discharged from services, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 24-hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, your credit card on file will be charged or you will be mailed a bill directly for the full session fee.

We appreciate your help in keeping the office schedule running timely and efficiently. By signing, you agree to the terms listed above.

Client Signature (Client's Parent/Guardian if under 18)

Date

Genardo Mental Health Counseling P.C.

395 Main Street, Suite 1
Oneonta, NY 13820
(607) 287-0058

Acknowledgement of Receipt of Client's Rights, Exemptions to Confidentiality and Privacy Practices

As mental health clinicians, we have an ethical and legal responsibility to maintain and protect your confidentiality as a client. We take this responsibility seriously and work hard to ensure the privacy of all clients is kept confidential. Although we strive for confidentiality, there may be exceptions in which we might have to break confidentiality:

Exceptions:

If the clinician believes that you may be a serious threat to yourself or someone else.

If the clinician learns of possible child abuse.

If the clinician is subpoenaed to testify in a court case.

The clinician believes there is custodial abuse, neglect, threats to harm yourself, threats to harm someone else, suicide gestures, as well as certain criminal offenses.

I have been supplied with a copy of the Patient's HIPPA Rights and Confidentiality. I have read and understand the information in the document. If I did not understand, I asked the clinician for clarification. By signing this document, I agree that I received and understand the Patient's HIPPA Rights and Confidentiality.

Client Signature: _____ Print Name: _____

Parent/Guardian Signature for Minor: _____ Date: _____

395 MAIN STREET, SUITE 1 ⁂ ONEONTA, NEW YORK 13820 ⁂ 607-287-0058 ⁂ therapy@genardocounseling.com

1) A person has a right to continuous, ongoing treatment with an individualized treatment plan and the right to participate to the fullest extent consistent with the patient's capacity, in his/her own treatment planning.
2) A person has the right to a full explanation of services rendered in accordance with his treatment plan.
3) Participation in an outpatient treatment program is voluntary and a person has a right to refuse treatment unless he/she is found to be legally incompetent and/or a danger to him/herself or others.
4) While a patient's full participation in his treatment is the central goal, objection to his/her treatment plan or disagreement with any portion of the plan shall not result in the patient's termination from treatment unless such objection renders the patient's continued participation in the treatment clinically inappropriate or would endanger the safety of him/herself or others.
5) The patient's clinical record shall be a confidential document maintained in accordance with Section 33.13 of the Mental Hygiene Law.
6) The patient shall be assured access to his clinical records in accordance with Section 33.13 of the Mental Hygiene Law.
7) The patient has the right to receive clinical care and treatment which is appropriately suited to his/her needs, skillfully, safely and humanely administered and with full respect for dignity and personal integrity.
8) A patient has a right to receive treatment in a manner that is non-discriminatory.
9) A patient has the right to be treated in a way which acknowledges and respects his/her cultural environment.
10) A patient has the right to privacy consistent with the effective delivery of treatment.
11) A patient has the right to freedom from abuse and mistreatment by an employee.
12) A patient has the right to request a change of therapist.
13) A patient has the right to terminate treatment, unless determined to be a danger to him/herself or others.
14) A patient has the right to be informed of the provider's grievance policy and procedure and to initiate any question, complaint or objection, in accordance to the policy.

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(607) 287-0058

Attendance Contract

As an individual receiving therapy services with Genardo Mental Health Counseling P.C., I agree to take an active role in the treatment process and follow all recommendations. I agree to be on time for all scheduled sessions. If I am unable to attend a scheduled session or if I will be more than 10 minutes late to a scheduled session, I will notify Genardo Mental Health Counseling P.C. either by phone or email. If I call and there is no answer, I agree to leave a detailed message on his confidential voicemail.

If I am more than 10 minutes late to a scheduled appointment, it is up to the discretion of the therapist to see you or reschedule your appointment to ensure the needs of other individuals receiving services are met.

Genardo Mental Health Counseling P.C. charges $294.00 per session; however, Genardo Mental Health Counseling P.C. also charges on a sliding scale. Keeping your scheduled appointments is an investment into you or your children and family's personal treatment and recovery. When you make an appointment with Genardo Mental Health Counseling P.C., you are asking a professional to hold a specific block of time for you. In order to efficiently serve the community, Genardo Mental Health Counseling P.C. has instituted a 24-hour notification for canceling an appointment. If you miss a scheduled appointment without calling to cancel, you will be responsible to pay the full amount of the scheduled appointment fee will be applied to your account which you will be responsible to pay since your insurance company will not cover missed appointments.

All payments including insurance co-pays and/or self-pay are due at time of service. This can be paid either by cash, check or credit card. A $30.00 fee will be instituted for returned checks.

Group Therapy: For a group to work effectively, it is important that you attend all scheduled sessions and be on time. If you decide to discontinue the group, I ask that you come to one more session to let the group know and say "goodbye."

By signing below, I agree to the terms of this Attendance Contract:

Client Signature: _____ Date: _____

Print Name: _____

Therapist Signature: _____ Date: _____

GENARDO MENTAL HEALTH COUNSELING P.C., (607) 287-0058

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up to date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

• That I have read or had this form read and/or had this form explained to me.

• That I fully understand its contents including the risks and benefits of the procedure(s).

• That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client: _____ Date: _____

Credit Card Form

Name as it Appears on Card: _____

Card#: _____ **Expiration Date:** _____

CUV: _____

By signing below, I give permission to Genardo Mental Health Counseling P.C. to keep my credit card on file to pay for any copays or charge the full-service fee if my insurance does not cover the session, if I do not complete the necessary paperwork to bill my insurance by Genardo Mental Health Counseling P.C. or Headway.co, if I do not show for a scheduled appointment without notice, if I cancel my appointment without giving a 24-hour notice, or if I am not paying with insurance or I am self-pay.

Signature: _____ Date: _____

Print Name: _____